

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>002858</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/11/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNING POINTE OF FRANKLIN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>75 S MILFORD DR</b> <b>FRANKLIN, IN 46131</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for Investigation of Complaint IN00104609.</p> <p>Complaint IN00104609 - Substantiated. No State deficiencies related to the allegations are cited.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to Complaint IN00103237.</p> <p>Dates of Survey: April 9, 10, 11, 2012</p> <p>Facility number: 002858 Provider number: 002858 AIM number: N/A</p> <p>Survey Team: Barbara L. Hughes, R.N.</p> <p>Census bed type: Residential: 35 Total: 35</p> <p>Census payor type: Other: 35 Total: 35</p> <p>Sample: 7</p> <p>Morning Pointe of Franklin was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00104609.</p> <p>Quality review completed on April 16, 2012 by Bev Faulkner, R.N.</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

PZET11

If continuation sheet 1 of 1